97th Congress
2d Session

COMMITTEE PRINT

OVERSIGHT OF THE SOCIAL SECURITY ADMINISTRATION DISABILITY REVIEWS

A REPORT

PREPARED BY THE

SUBCOMMITTEE ON OVERSIGHT OF GOVERNMENT MANAGEMENT

OF THE

COMMITTEE ON GOVERNMENTAL AFFAIRS

UNITED STATES SENATE

AUGUST 1982

Printed for the use of the Committee on Governmental Affairs

U.S. GOVERNMENT PRINTING OFFICE
97-957 O WASHINGTON : 1982

S402-11

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LETTER OF TRANSMITTAL

U.S. SENATE, COMMITTEE ON GOVERNMENTAL AFFAIRS,
SUBCOMMITTEE ON OVERSIGHT OF GOVERNMENT MANAGEMENT,

Washington, D.C., August 24, 1982.

Hon. WILLIAM V. ROTH, Jr.,
Chairman, Committee on Governmental Affairs, Dirksen Senate Office Building, Washington, D.C.

DEAR MR. CHAIRMAN: The Subcommittee on Oversight of Government Management transmits the following report on the Social Security Administration's reviews of the continued eligibility of individuals receiving Title II disability insurance benefits.

In 1980, the Congress passed legislation which mandated the Social Security Administration to conduct continuing disability investigations of beneficiaries with non-permanent disabilities once every three years. These periodic reviews were intended to ensure that only those who are severely disabled and unable to work continue to receive benefits.

After receiving a large number of complaints that severely disabled persons were being terminated from the program, the Subcommittee held a hearing on May 25, 1982, to examine how the reviews were being conducted and what their impact was on beneficiaries and the disability program itself. The Subcommittee received testimony from a range of witnesses, including the Social Security Administration, the General Accounting Office, administrative law judges, and groups representing beneficiaries, doctors, and lawyers.

The Subcommittee's principal finding is that many severely disabled people are being erroneously and unjustly terminated from the disability insurance program, only to wait without benefits through a lengthy appeals process which reinstates 67 per cent of those claimants who appeal. The Subcommittee finds that this needless and unjustifiable result is attributable to several factors—some of which are longstanding problems in the disability program and others which result from the way the reviews are being conducted.

The Subcommittee recommends that legislation be passed which will address both the longstanding deficiencies in the disability program and the problems in the management of these reviews. The proposed legislation would provide short-term protection for beneficiaries until the Congress approves more comprehensive reforms.

The Subcommittee recognizes that as much as Congress wants to remove persons from the program who do not belong there, it also wants to ensure that severely disabled persons remain in the program. The recommendations made by the Subcommittee seek to

guarantee a fair and efficient review of eligibility which will meet this goal.

Sincerely,

WILLIAM S. COHEN,
Chairman.

CARL LEVIN,
Ranking Minority Member.

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I. INTRODUCTION

On May 25, 1982, the Subcommittee on Oversight of Government Management held a hearing to examine actions taken by the Social Security Administration in reviewing the continued eligibility of individuals receiving disability benefits under the Title II Disability Insurance program.[1] This hearing was held after the Subcommittee received a large number of complaints that severely disabled persons were being terminated from this program because of the way in which the reviews were being conducted. The Subcommittee determined that these reports were not unique to individual states, but were prevalent across the country.

Under current law, those who qualify for Social Security disability benefits must meet very stringent criteria. They must be so totally disabled that they not only cannot perform the work they had previously done, but also cannot engage in any kind of substantial gainful work which exists anywhere in the country.

Even with such stringent eligibility requirements, common sense dictates that a periodic review of the medical conditions of those in the program is necessary, and prudent management should certainly require no less. In 1980, in response to a number of studies confirming the need for improved program management, the Congress passed legislaton which mandated the Social Security Administration to conduct continuing disability examinations of individuals with non-permanent disabilities once every three years.[2]

These periodic reviews were intended to ensure that only those who are severely disabled and unable to work continue to receive benefits. Congress specifically directed the Social Security Administration to begin these reviews in January, 1982, in order to allow time to establish the necessary procedures and to hire and train additional staff to ensure that the reviews would be conducted efficiently and fairly.

This planned delay was crucial because the reviews were to be conducted by 50 separate state disability determinaton agencies, each with differing funding and staffing levels. It was also important because the 1980 amendments also imposed other new requirements on the disability determination process. These reforms were designed to address longstanding problems in the program's administration such as case overloads, unreasonable case processing and appeals delays, and confusion between state and federal decisionmakers over the criteria for disability determinations.

When the current Social Security Administration management team assumed responsibility for this program in January, 1981, it

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[1] Cash benefits under Title II of the Social Security Act disability insurance (DI) program are paid to workers who are unable to work due to severe physical or mental disabilities. The benefits are financed by worker contributions which are paid into a separate Disability Insurance Trust fund. 42 U.S.C. 416 et. seq.; 20 CFR 404.

[2] Social Security Disability Amendments of 1980 (P.L. 96-265).

inherited the problems noted above and it inherited the mandate of all the 1980 amendments. However, rather than waiting until 1982 as the Congress had recommended, the Social Security Administration, as part of the President's Economic Recovery Initiative, decided to start the reviews early and increase the volume of reviews.[3]

As a result, in March 1981, the Social Security Administration started sending state disability offices the first of 357,000 cases to be reviewed by the end of the year, although previously the states had only reviewed 160,000 cases per year. In 1982, the Social Security Administration had planned to send 567,000 cases to states for review, and another 840,000 in 1983.[4]

Predictably, the increased volume of reviews added onto an already troubled system, exacerbated existing problems, and generated reports that thousands of severely disabled persons were being erroneously dropped from the program.[5]

Reports from all over the country revealed a disturbing pattern of burgeoning caseloads and backlogs at all levels, poor development of medical evidence, undue reliance on hasty and incomplete consultative examinations, a disregard for the beneficiaries' complete medical history, and inadequate notice to beneficiaries.

The Social Security Administration's own statistics revealed that between March, 1981 and April, 1982, the SSA reviewed 405,000 disability cases and nearly half—191,000 were terminated from the program, far exceeding SSA's own projection that 20 per cent of the recipients were ineligible.[6]

Yet, 67 per cent of those who appeal their benefit terminations are subsequently reinstated to the program after hearings where administrative law judges [ALJs] find that they are still severly disabled and deserve to remain in the program.[7] For that period alone, at least 36,000 beneficiaries were erroneously terminated from the program, only to be later reinstated by ALJs. Disability benefits, however, are terminated two months after the initial decision and do not continue during the appeal process.

Most disturbing about this costly and wasteful effort of removing and subsequently reinstating severely disabled persons is the fact that the wait for reinstatement of benefits stretches from nine to twelve to sixteen months [8]—months when needed benefits are not

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[3] Memorandum dated March 13, 1981, from Fred Schutzwatt, Acting Deputy Commissioner (Operations) to All Regional Commissioners, Social Security Disability Insurance Program, Hearings before the Subcommittee on Oversight of Government Management, Committee on Governmental Affairs, pp. 151.

[4] Id. On September 8, 1982, the Social Security Administration announced a 20 per cent reduction in the number of cases slated for reviews.

[5] See prepared statements of Jonathan Stein, Esq., Community Legal Services, Inc., Philadelphia, Pennsylvania, hearing record pp. 95–116, and Kathleen Grover, Esq., Holder and Grover, Portland, Maine, hearing record. pp. 84–94; written testimony of American Psychiatric Association, hearing record pp. 325–329; National Senior Citizens Law Center, hearing record pp. 253–273 National Mental Health Association, hearing record, pp. 330–331; the City of New York, hearing record pp. 286–324; also see selected letters from Subcommittee files, hearing record pp. 435–467; selected case summaries from Subcommittee files, hearing record pp. 425–434; Selected press clippings from Subcommittee files, hearing record pp. 468–508.

[6] Contained in SSA's May 17, 1982 response to Apr. 27, 1982 letter from Subcommittee, hearing record p. 173.

[7] SSA memorandum dated May 14, 1982, from Beverly A. Bedwell, Associate Commissioner of Assessment, to Commissioner of Social Security, hearing record p. 190.

[8] Testimony of Paul Simmons, Deputy Commissioner for Programs and Policy, SSA, hearing record p. 10; testimony of Judge Francis O'Bryne, Office of Hearings and Appeals, SSA, Chicago, hearing record p. 125; testimony of Kathleen Grover, hearing record, p. 69; testimony of Jonathan Stein, hearing record p. 77.

paid to severely disabled persons who have worked and paid for the right to those benefits.

This anomalous result and its tragic human cost were confirmed further by a General Accounting Office [GAO] investigation into the way the reviews were being managed. The resulting report, issued to the Subcommittee in May, reached this disturbing conclusion:

> . . . many of those losing their disability benefits have been on the SSA rolls several years, still have what we would all consider to be severe impairments, and have experienced little or no medical improvement. This raises questions about how and why these people are being terminated, and the fairness of the SSA's decisions." [9]

That a periodic review of continued eligibility is a needed and valuable management tool is beyond dispute. Congress mandated these reviews, but failed to establish specific guidelines for their conduct. Nonetheless, it should be clear to all that as much as Congress wants to remove persons from the program who do not belong there, it must, with at least equal fervor, ensure that severely disabled persons remain in the program.

The Subcommittee's inquiry into the management of the review process sought to answer the principle concern raised—why severely disabled people are being unfairly and erroneously terminated from the disability insurance program. As a result, we examined the following questions:

How does the SSA determine the number of cases for review and how are specific cases selected for review?

What impact have the increased reviews had on existing problems in the program, particularly caseloads and backlogs, and how has that impact affected the quality of disability decisions?

Under what standards are the disability decisions being made? How are the reviews being conducted? What medical evidence is being gathered and how is it evaluated?

What notice is given to beneficiaries regarding the nature and potential impact of the reviews?

What changes are needed to improve the management of the review process and protect severely disabled recipients?

The following witnesses appeared at the hearing:

The Honorable Paul B Simmons, Deputy Commissioner for Programs and Policy, Social Security Administration;

Rhoda Greenburg, Director, Social Security, Office of Disability Programs;

Beverly A. Bedwell, Associate Commissioner, Office of Assessment, Social Security Administration;

Donald A. Gonya, Assistant General Counsel, Social Security Division, Social Security Administration;

Louis B. Hays, Associate Commissioner, Office of Hearings and Appeals, Social Security Administration;

Ethel A. Kage, Reed City, Michigan;

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[9] General Accounting Office, "Social Security Administration's Efforts to Re-examine the Continuing Eligibility of Disabled Persons" (GAO/HRD-82-91), July 14, 1982, p. 6.

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Kathleen Grover, Esq., Holder and Grover, Portland, Maine;

Jonathan M. Stein, Esq., Chief of Special Projects, Community Legal Services, Inc., Philadelphia, Pennsylvania;

Judge Francis O'Byrne, Office of Hearings & Appeals, Social Security Administration, Chicago, Illinois;

Herbert L. Brown, Administrator, Tennessee Disability Determination Section, Nashville, Tennessee.

In preparation for the hearing and subsequently, the Subcommittee received written statements, letters and telephone calls from individual beneficiaries and their families and representatives, and from administrative law judges, state disability determination offices, Social Security disability examiners and claims representatives, social workers, psychiatrists, physicians, and lawyers. In addition, information was submitted by many organizations concerned with the interests of the elderly, and the physically and mentally disabled, including the National Senior Citizens Law Center, the National Mental Health Association, the American Psychiatric Association, the Save Our Security Coalition, to name a few.[10]

[10] Supra fn. 5. See also, hearing record, pp. 332–420.

II. OVERVIEW OF DISABILITY INSURANCE PROGRAM

A. Legislative History of Disability Insurance Program

The Social Security Disability Insurance program was established in 1956 to provide cash benefits to workers who later suffer severe disabilities. In order to be eligible for benefits, a person must have worked and contributed to the disability insurance program for a certain number of years.[11]

The statutory definition of disability under this program is considered to be a very strict one which only the severely disabled can meet. Partial disability, recognized in many other benefit programs, is insufficent to qualify for Social Security disability insurance benefits.

The current disability definition requires that a worker's mental or physical impairment be ". . . of such severity that he is not only unable to do his previous work but cannot, considering his age, education and work experience, engage in any kind of substantial gainful work which exists in the national economy, regardless of whether such work exists in the immediate area in which he lives, or whether a specific job vacancy exists for him, or whether he would be hired if he applied for work."[12] Vocational factors (age, education, work skills, etc.) are only to be used to determine whether the person was able to perform work, not whether the person was actually able to obtain work.[13]

The disability insurance program is financed through a payroll tax paid into a separate Disability Insurance trust fund. A recent House Select Committee on Aging report states that under all economic and demographic assumptions and projections, the DI trust fund is healthy and solvent and will remain so at least through the year 2060.[14]

In January, 1982, the SSA Disability Insurance program paid benefits to 2.76 million disabled workers, their 1.258 million children, and 429,000 spouses. A total of 4.456 million people receive Disability Insurance benefits.[15] The average monthly benefit for disabled workers as of November, 1981 was approximately $413.

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[11] Currently, these requirements are that workers (other than the blind) who are disabled and over age 31 must have worked and been covered by Social Security for 5 of the last 10 years prior to disability. If under age 25, the requirement is 1½ years of work out of the three years prior to disability and for workers age 25 through 31, a similar ratio is in effect. Title II Social Security Act, § 213, 216; 20 CFR § 404.101 et seq.

[12] Title II Social Security Act § 223(d).

[13] Senate Special Committee on Aging, "Social Security Disability: Past, Present, and Future," March, 1982, p. 5.

[14] House Select Committee on Aging, "Impact of the Accelerated Review Process on Cessations and Denials in the Social Security Disability Insurance Program," May 21, 1982, p. 3.

[15] Statistics from Social Security Administration's response to April 27, 1982 letter from Subcommittee—retained in Subcommittee files.

Their dependent spouses and children received average monthly benefits of $122 and $123, respectively.[16]

The number of disability insurance claims rose considerably during the early and mid-1970's, as did the number of benefits awarded, but the rate of benefit allowances to claims actually declined.[17] Since 1979, however, the number of initial claims resulting in benefit allowances at the state level has dropped significantly.[18] At the same time, the number of reconsideration requests rose considerably, but the allowance rates at reconsideration declined substantially to a point where only 13 percent of reconsideration requests resulted in a reversal of the state DDS' original decision.[19]

It is not surprising then that during the last 10 years the number of ALJ hearings has also climbed. In fiscal year 1970, only 34,000 ALJ decisions were made compared to 75,000 in 1975, and 172,000 in 1980. Nor is it surprising that as the state reconsideration rate of reversals declined from 33 percent to 15 percent, the rate of ALJ reversals rose from 42 percent to 58 percent in initial decisions.[20]

Still, the actual number of benefit awards under the disability insurance program from all levels of decisionmaking has continually declined since the 1975 peak, as has the total number of beneficiaries.[21]

B. Steps in Evaluating Disability Claims

Social Security Administration regulations[22] and written guidelines define the standards for evaluating disability claims. These regulations lay out a sequential evaluation process in determining whether an individual meets the statutory definition. These are the steps in that process:

1. Is the person currently engaged in substantial gainful activity (SGA)?

SGA is defined as any activity resulting in earnings greater than $300 per month. If the person is earning more than that amount, he is presumed not to be disabled under the SSA definition.

2. Does the person have a "severe" impairment?

"Severe" impairment is one that "significantly limits physical or mental activity to do basic work activities." If there is no severe impairment, the claim is denied on this medical condition alone.

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[16] The majority of disabled workers are over age 55. About 30 per cent of all benefit allowances in recent years have been made to workers over age 60. An additional 24 per cent are between the ages of 55 and 60, and 15 per cent are aged 50 to 54. Supra fn. 14.

[17] In 1970, 4.9 benefit awards were made for every 1,000 insured workers; by 1975, that rate had peaked at 7.5, but has since declined in 1980 to 4.1. The actual number of disabled benefit awards per year rose between 1971 and 1975 from 406,000 to 603,000. But it too dropped to 392,000 in fiscal year (FY) 1980 and to 358,000 in FY 1981, the lowest level since 1970. House Subcommittee on Social Security, Committee on Ways and Means, Status of the Disability Insurance Program, March 16, 1981, p. 20.

[18] Between 1970 and 1978, 40 percent of all initial claims were allowed at the state level. But, starting in 1979, this percentage dropped to 37 percent, to 33 percent in 1980, to 29.8 percent in 1981; Id. at 15.

[19] In 1970, a little over 100,000 reconsideration determinations were made, but that number increased to over 200,000 in 1975, and to 300,000 in FY 1980. Id. at 15 and p. 2.

[20] "The Bellmon Report;" Report by the Secretary of Health and Human Services on Implementation of § 304(g) of P.L. 96-265, Social Security Disability Amendments of 1980, p. 8; see also supra fn. 19 at p. 16.

[21] Id.

[22] 20 CFR 400 et. seq.

3. If the person does have a severe impairment that is expected to result in death or last for 12 months, the next question is whether the impairment meets or equals the degree of severity in the SSA's Medical Listing of Impairments. The Listings described specific diagnostic symptoms and clinical laboratory findings for various impairments which are considered severe enough to prevent a person from doing any gainful activity.

If the person's symptoms and clinical test findings meet those listed in the SSA regulations, the person is eligible for benefits. If not, but the person suffers from several impairments, the person may still be found disabled on the grounds that, in combination, these several impairments equal in severity an impairment found in the listings.

4. If the person is not found to be disabled based on the medical listings, a determination is made to determine whether the person can still do his past work. This determination (referred to as his "residual function capacity"—RFC) is based on the person's actual physical capacity (strength, mobility, etc.) and his mental or sensory abilities. If it is found that the past work can be done, the claim is denied.

5. If the person is found to be unable to do his past work, the next determination is whether the person can do any work which exists anywhere in the national economy. Age, education, training and work experience are evaluated along with the RFC results. If such a job listing is found, regardless of its actual availability, the claim is denied.

Obviously the disability decision is a very complicated determination requiring a careful weighing of medical and vocational factors.

C. Administration of Disability Determinations

Under an unusual Federal-State agreement, administration of the disability insurance program is carried out by each state under contract with the Social Security Administration. The state agencies' primary role is to develop all necessary medical and vocational information, evaluate it, and determine whether the person meets the federal statutory definition of disability. All costs incurred by state agencies are funded by the federal government.

State agency decisions are governed by the SSA-issued Program Operations Manual System (POMS), which are internal written guidelines based on federal regulations and law, but which differ in significant ways from the regulations and the law. The POMS, however, are not subject to public notice and comment.[23]

The administrative procedure for reaching disability determinations and appealing disability decisions is as follows:[24]

1. Initial determination by SSA district offices and State Disability Determination Service

Disability insurance benefit applications are filed in SSA district offices. The district offices then gather medical information from doctors, hospitals, or clinics where the person has been treated, as

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[23] See § VII(c) to follow.

[24] Adapted from procedural description contained in "The Bellmon Report," supra fn. 20, pp. 5–7.

well as non-medical information regarding work history and worker contributions to the disability trust fund. Claims can be denied here for non-medical reasons, i.e., based on evidence that a person is currently working and earning over $300 per month, or that he or she has not contributed to the program long enough to qualify.

Absent a denial based on non-medical factors, all the information gathered by the district office is sent to the state disability determination service (DDS). The DDS disability examiner in turn requests medical reports from doctors who have treated the person in the past. If additional medical information is needed, the DDS may also require clinical and laboratory tests and consultative medical examinations by other private doctors whose fees are paid by the DDS.

The disability examiner and a DDS staff physician together then review all the evidence. The DDS staff doctor determines whether the medical evidence shows that the person's impairments meets or equals the severity of the medical impairments listed in the POMS. The disability examiner, in turn, determines whether, in view of the impairments, the person can perform in any job which exists anywhere in the national economy, considering the person's age, education, and work experience.

The DDS decision is issued as an SSA decision; if the person's application for benefits is denied, the notice advises the person of his or her right to appeal.

2. Reconsideration of decision by State DDS

Persons denied benefits by the DDS have the right to have their claims reconsidered by other personnel within DDS, if requested within 60 days. The person is allowed to submit additional information. If denied here, the person again receives formal written notice and advice on further appeal rights.

3. Administrative law judge (ALJ) hearing

If the person so requests within 60 days, he or she is entitled to a hearing in front of an administrative law judge, an experienced trial attorney specifically trained to adjudicate disability claims. The hearing is the first opportunity for the person to actually meet face-to-face with a decision-maker.

The person may submit additional evidence (the record remains open after the state DDS decision), produce witnesses, and be represented by a lawyer or other representative. The ALJ may also request the appearance of medical and vocational experts. The hearing is not considered adversarial and as such, the SSA has no representative at the hearing.

Because the record has remained open and testimony will be considered for the first time, the ALJ hearing is actually a de novo consideration of the person's disability claim. It is not simply a review of the state DDS decision. The ALJ is not governed by the POMS which dictate state DDSs, but rather must follow the Social Security statute, federal regulations, Social Security rulings, and federal court decisions. However, the same basic sequential steps are used in determining eligibility, but factors such as the impact

of pain and the person's own credibility and appearance are also evaluated.

Testimony is taken under oath and a transcript is made. The ALJ issues a formal, written decision detailing the reasons for denial or acceptance.

4. Appeals council review

Following the denial of a claim by an ALJ, the person may request review by the Appeals Council, if done within 60 days. The Council is a 15-member panel with the discretion to accept or deny a request for review; it is located within the Office of Hearings and Appeals. If review is granted, the review is based solely on the record, and no appearances are allowed. It may uphold or change the ALJ's decision or remand it to the ALJ for additional consideration.

5. Federal district court

The Appeals Council is the final SSA decisionmaker and the last administrative remedy. If the person's claim is denied there, federal district court is the remaining appeals avenue.

III. HISTORY OF MANAGEMENT PROBLEMS IN THE DISABILITY PROGRAM

The disability program has a long history of congressional and General Accounting Office criticism of its administration. Because it is a major federal program run by 50 different state DDS agencies, much of the criticism has centered on the lack of federal monitoring of disability decisions and program administration.

One early problem was the SSA's difficulty in issuing adequate and timely criteria for determining disability. As early as 1960, the House Ways and Means Subcommittee on Social Security recommended that the SSA provide disability examiners and ALJs explicit guidance on how to apply vocational standards.[25] In 1974, a Subcommittee staff report again called for clear guidelines on vocational factors. Nevertheless, regulations were not published on vocational factors until 1978, 20 years after the original recommendation.[26]

The GAO pointed out that medical listings of severe impairments issued in 1968, for state agency use, lacked specificity and failed to take into account continuing advances in medical technology.[27] GAO also noted that state agencies complained that the listings were too time consuming and too expensive to use. The SSA spent several years updating the listings, which were finally published in 1979.[28]

In the mid-1970's, there was an enormous increase in the number of claims to be processed by state disability agencies. In 1972, the Department of Health, Education, and Welfare was directed to administer the black lung benefits program. As a result, with only a few weeks notice, SSA shifted large numbers of DI claims personnel into processing black lung claims. By 1972, over 340,000 black lung claims had been filed, on top of an already tremendous backlog. This high volume workload, plus 183,000 more black lung claims in 1972, took a heavy toll on SSA headquarters, and especially in SSA and DDS offices in coal mining states.[29]

In 1974, Congress created the supplemental security income (SSI) program to replace state-run welfare programs for the aged, blind, and disabled.[30] The program supplements the income of needy persons who are not covered under the social security disability program. Disability benefits under SSI are also administered by SSA's

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[25] House Subcommittee on Social Security, Committee on Ways and Means, "Disability Adjudication Structure," January 29, 1978, pp. 8–9.
[26] House Ways and Means Committee, "Staff Report on the Disability Insurance Program," July 1974.
[27] General Accounting Office, "The Social Security Administration Should Provide More Management and Leadership in Determining Who Is Eligible for Disability Benefits" (HRD–105).
[28] Id.
[29] Supra fn. 26.
[30] Id.

Office of Disability Program under a management scheme which is virtually identical to the Title II Disability Insurance program.

As a result, in January, 1974, about 1.3 million blind and disabled persons were brought into the SSI program from the former state welfare programs. By the end of 1975, the number had reached almost 2 million. This influx resulted in a decline in the number of Title II cases reviewed and in the level of quality assurance.[31]

The DI program itself also was undergoing a dramatic increase in the early and mid-1970's, before leveling off in the late 1970's and then declining. Between 1970 and 1976, DI rolls alone almost doubled, from 1.5 to 2.7 million recipients.[32]

No studies have conclusively provided the specific reasons for the growth in the DI program (which paralleled growth in state and civil service disability programs), but a combination of factors is usually cited: greater awareness of DI programs; poor economic conditions and high unemployment; greater social acceptance of disability. Others also point to weak federal management and poor federal monitoring of the program as factors in the increasing number of beneficiaries.[33]

Whatever the exact cause of the growth in the program, the problems which existed in the program were exacerbated by the increased caseload and many still remain. The major problems are discussed below.

A. Delays in Processing Cases and Hearings and Appeals Procedure

As early as 1959, the GAO found that the handling of applications for disability benefits was cumbersome and resulted in unnecessary costs and excessive processing time.[34]

In 1974, the median processing times for regular DI claims, before the impact of SSI and black lung was felt, raised questions in themselves: 75 days for initial decisions, 64 days for reconsideration of initial denial, and 163 days for ALJ hearing.[35]

The "question of whether a claimant becomes exhausted in the process of exhausting his administrative remedies" became the central focus of concerns about delays in processing.[36]

SSA employs about 700 ALJs to hear claimants cases involving DI, SSI, black lung and retirement claims. About 95 percent of the hearing results in 1980 involved disability claims. The SSA claimants' hearing requests rose from 154,962 in fiscal year 1975 to 252,023 in fiscal year 1980.[37]

A January, 1978, House Ways and Means report, "Disability Adjudication Structure," examined problems of delay in both the initial determination stage and the hearings and appeals process. The

[31] Supra fn. 13, p. 7.
[32] Id.
[33] Id. at 9.
[34] Supra fn. 26 at 4.
[35] Id. at 5.
[36] Id.
[37] General Accounting Office, "Social Security Administration Policies for Managing Its Administrative Law Judges," HRD-81-90, June 2, 1981, p. 1.

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Committee was unable to conclude what, if any, structural changes could alleviate the delay problems.[38]

Delays have been so bad that several lawsuits have been brought to impose a strict time limit for hearing cases. A district court in Kentucky imposed a 90-day limit on hearing cases at a time when the average processing time was about 220 days. The government appealed and the Sixth Circuit (*Blackenship* v. *HEW,* 587, F. 2nd 329 (1978)) vacated the decision saying that although 220 days was not reasonable, neither was 90 days. The case was remanded with instructions to HEW to promulgate a reasonable time limit, which HEW tried to do in August, 1980, proposing a 165-limit.

B. Conflict between State Agency and ALJ Decisionmaking Standards and Results

When state agencies evaluate and decide a disability claim, they are governed by very rigid and stringent sequential evaluation guidelines. The decision is also made without any face-to-face contact with the claimant.

ALJs, on the other hand, are not governed by those rigid internal SSA guidelines. They are governed by SSA's federal regulations in addition to SSA law and pertinent court decisions, to which state agencies do not adhere. Significantly ALJs also have the benefit of face-to-face testimony from the claimant, who may also be represented by counsel. ALJs have the opportunity to assess the claimant's credibility, particularly as it relates to pain or the combined effects of a number of impairments. It is important to note that the claimant is also allowed to submit any additional evidence gathered since the state agency's decision.

Because of these differences, the scope of an ALJ's review of a case is much broader than that of the state agencies. In fact, the ALJ hearing is a de novo hearing, where the ALJ is not bound by previous determinations but must make a new and independent decision based on evidence presented him. The ALJ's decision is a new one, based on different and additional evidence, rather than simply a "reversal" or acceptance of the original state decision.

It is not surprising then that there has been such a discrepancy in the outcome of case decisions at the state level and at the ALJ level, or that this discrepancy is so entrenched in the structure of the DI appeals process. In 1970, state agencies denied about 60 percent of initial claims, of which 42 percent were allowed on appeal. By 1980, state agencies were denying 70 percent of initial claims, of which nearly 60 percent were allowed on appeal. The rate of allowances at the ALJ level in termination cases is slightly higher—nearly 64 percent.[39]

C. Consultative Examinations—No Managerial Controls

Consultative examinations play a key role in the disability determination process. State agencies are authorized to buy medical evidence to clarify findings and diagnoses, and in cases under review, to resolve the issue of current medical condition.

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[38] Supra fn. 25.
[39] Supra fn. 20, p. 8; Supra fn. 17, p. 27.

Expenditures for consultative examinations represent a significant portion of the SSA disability program administrative costs. These costs have increased from $51.6 million in fiscal year 1975 to $75.8 million in fiscal year 1978, to $137 million in fiscal year 1981. The percentage of cases in which CEs are purchased has also risen from 19.7 percent in fiscal year 1975 to 30.2 percent in fiscal year 1978 to 40 percent in fiscal year 1980.[40]

Yet in 1977, when the SSA studied the relationship between consultative examinations and the quality of disability decisions, no discernable difference as to the quality or accuracy of the decisions in cases with and without consultative examinations could be found.[41] The review indicated that evidence from treating physicians was not pursued adequately, consultative examinations were purchased unnecessarily, and consultative examination reports were often inadequate for state agency use.

A 1979 GAO report concluded that the usefulness of the consultative examinations purchased was not well documented. At that time, the SSA had no way of determining whether money was being spent unnecessarily on consultative examinations, or how much was paid for examinations which were not comprehensive.[42]

D. Failure to Periodically Review Recipients' Eligibility

When a person is awarded benefits under the disability program, the case is placed in one of three classifications: "permanent"—cases where the impairment is one of 12 listed conditions, with little or no chance of improvement; "diaried"—cases where the impairment may improve, so the case is "diaried" with a set date for review; and "non-permanent"—cases with impairments which are not considered permanent, but where the chances of improvement are not certain enough to diary the case.

The continuing disability investigation (CDI) process is SSA's way of identifying beneficiaries who may have regained the ability to work. The review of diaried cases has been SSA's principal effort to identify ineligible beneficiaries.

If the SSA receives specific information indicating that a person on disability has returned to work, then a CDI would be triggered. But other than CDI reviews on diaried cases and on cases where there is evidence of work activity, there has been no on-going review of the other non-permanent and permanent cases.

In earlier years, about 130,000 CDIs were done annually. This level of review did not change much over the years even though the number of disabled workers entering the DI rolls grew dramatically. In 1976, 5.7 percent of the 2.6 million disabilities were subject to a CDI; by 1980, only 6.5 percent of the 2.8 million recipients had a CDI.[43]

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[40] General Accounting Office, "Controls Over Medical Examinations Necessary for the Social Security Administration to Better Determine Disability" (HRD-79-114), October 9, 1976, p. 6.
[41] Id. at 7.
[42] Id. at 28.
[43] Supra fn. 17, p. 25.

IV. 1980 AMENDMENTS TO THE SOCIAL SECURITY ACT

As a result of these and other managerial and structural problems in the disability program, a series of amendments was passed in 1980. These amendments mandated several changes in the disability program.

A. Periodic Review of Disability Cases

A provision requires that a CDI be conducted once every three years for all non-permanent, non-diaried cases. For cases with permanent impairments, the SSA was authorized to review those at intervals set at its discretion; the SSA subsequently decided to review permanent cases once every five years.

It should be noted that this change did not give the SSA any new authority. The SSA had always had the responsibility and authority to continuously monitor the continuing eligibility of disability recipients. The 1980 amendment merely established a firm, minimum review requirement.

These mandated periodic reviews, however, were not intended to replace the existing annual eligibility reviews already conducted by SSA. Rather these new CDIs were to be conducted in addition to these determinations.

This change in the law was not to go into effect until January, 1982.

B. Federal Review of DDS Decisions

Another change requires SSA to review, before the state's decision goes into effect, 15 percent of all DI allowances in fiscal year 1981, 35 percent in fiscal year 1982, and 65 percent in fiscal year 1983 and thereafter. The main impact of this provision on the state agencies is in the time needed to manually select sample cases and rehandle cases that are returned for corrective action.

Another amendment also requires the Appeals Council to review 35 percent of all favorable ALJ decisions, beginning in 1981. No review of denials is required.

C. Tighten State Administration of Disability Program

This change authorizes the Federal government to assume a state's disability function if the state is unable to meet new speed and accuracy case handling goals. Regulations promulgated in May, 1981, prescribe specific standards for accuracy of performance and processing time that state agencies must meet in making disability determinations, or risk federal takeover of the state's disability function (effective June 1, 1981).[44]

[44] 20 CFR § 404.1502 et. seq.

D. Personalized Denial Notices

Starting in June, 1981, personalized notices were required in all adverse disability decisions. These notices now include a listing of the doctors consulted and a short recitation of the reasons for denying the disability claim or for terminating benefits. Nonetheless, this change required extensive revision of forms and additional staff training. It was estimated that this change added 1½ to 2 hours to the time needed to process a case.[45]

V. ACCELERATION OF CDI REVIEWS

A. Background

According to President Reagan's "Program for Economic Recovery," the SSA contemplated sizable savings by tightening the administration of the disability insurance program. Savings were projected to be $200 million in 1982 rising to $900 million in 1985. According to the Administration:

> The General Accounting Office (GAO) in a draft report has stated that:
>
> There may be as many as 584,000 beneficiaries not currently disabled but still receiving disability benefits. These beneficiaries represent over $2 billion annually in Trust Fund costs.
>
> Social Security Administration (SSA) studies confirm that huge sums are paid incorrectly to individuals misclassified as disabled. *As a result, DI caseloads have risen by 80 percent since 1970, and costs have climbed by 500 percent.* Under the direction of this Administration, the SSA will begin to intensively review cases to insure *that only the truly disabled receive disability benefits."* (emphasis added)[46]

The March 30, 1981, GAO report did estimate that based on a nationwide review of 3,000 cases, conducted by the SSA itself in 1979, 20 percent of the 2.9 million DI beneficiaries did not meet the SSA's current criteria. However, the GAO cautioned that although the pilot study showed that 20 percent were not disabled, the actual termination rates would not be that high because of the appeals process and the opportunity for a more thorough review. Nor did the GAO embrace the 20 percent estimate as being an accurate one.[47]

Nonetheless, the GAO concluded that the pilot study was a good indicator that ineligibility was a costly problem which had to be corrected. GAO recommended that the SSA expedite its efforts to re-evaluate the DI rolls and provide the necessary resources to support those efforts.[48]

The increased DI caseloads and costs referred to in the Administration's "Economic Recovery Plan" had never before been solely attributed to ineligible beneficiaries in the program. Rather, as stated earlier, the increased caseloads and costs are generally attributed to a variety of factors: worsening economic conditions and

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[46] Supra fn. 17, p. 3.

[47] General Accounting Office, "More Diligent Followup Needed To Weed Out Ineligible SSA Disability Beneficiaries" (HRD-81-48), March 3, 1981, p. 8.

[48] Id.

unemployment; changing attitudes toward receiving benefits and greater publicity as to the availability of benefits; requirements of other public and private disability plans which mandate disability applications; lax federal management.[49]

Although the 1980 amendments were not effective until January, 1982, the SSA decided to start the periodic reviews in March, 1981. On March 13, the SSA sent a memorandum to all its regional commissioners entitled "Implementing the Administrative Initiative in President's Reagan's Economic Recovery Plan—Accelerating SSA's CDI Effort—ACTION."[50] This memorandum detailed the SSA's plans for accelerating CDI reviews during the remainder of 1981, and for implementing the periodic reviews mandated for 1982.

The 1980 amendments on periodic reviews gave no guidance on how cases were to be selected for reviews. The SSA memorandum detailed the SSA's plan for selecting cases. Basically, in March and April, 1981, the SSA sent out 64,000 cases to the states for review. These 64,000 cases were chosen from a pool of 210,000 cases where the person was under age 50 and had entered the program in the years 1973–75 (years the SSA considers particularly error-prone because of the big influx of cases and poor case reviews).

For the remainder of 1981, the SSA developed more specific case profiles based on age, dollar amount of benefit, date enrolled and, using those profiles, planned to send 30,000 cases a month out to the states for review. The plan then was to develop a more sophisticated way of selecting cases which were high benefit cases of younger workers with the greatest likelihood of cessation—so that the reviews could be done to achieve the greatest dollar savings.[51]

B. Procedures for CDIs

Cases which are selected for review are sent from the SSA's central office in Baltimore to the DDS office in the state where the recipient lives. Once the state agency receives the file, it does the following:

1. The DDS sends a notice to the beneficiary that a review of his or her disability is underway, and includes a four-page form requesting information on the person's current ability to work and current doctors seen.

2. The DDS reviews the form and contacts the beneficiaries' treating physicians for current medical information. The specific doctors the SSA chooses to contact is discretionary, but doctors may be contacted by phone or mail and may be requested to provide current medical information. The GAO reports, however, that in five states it visited, doctors seen by the recipient more than three months prior to date of review usually were *not* contacted because the medical information was not considered "current" enough.[52]

3. The DDS may require the recipient to get a consultative examination from a doctor paid by the SSA. Under the SSA's written guidelines, a consultative examination should only be requested

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[49] Supra fn. 13.
[50] Supra fn. 3.
[51] Supra, fn. 6, hearing record p. 176–177.
[52] Supra fn. 9, p. 10.

when there is a conflict between the recipient's assessment of his condition and the assessment given by his treating physician, or where the treating physician's report is inadequate to reach a conclusion.[53]

4. DDS sends a notice to the beneficiary that, based on the treating physicians' reports and consultative examination, the beneficiary is no longer disabled and benefits will be terminated two months from the date of the notice, or that benefits will continue.

The notice states that the beneficiary has 10 days to submit additional information, or to request additional time to gather information, before the case file is sent to the SSA in Baltimore for the official termination decision.

5. If the beneficiary does not respond within 10 days, the case is sent to the SSA in Baltimore, formal notice of termination is sent, and the beneficiary is advised of his or her appeal rights. The same appeal procedure applicable at denials of initial applications is available for disability terminations: reconsideration at the state level; then, ALJ review, Appeals Council, and federal district court.

While the written procedures on the content of notices are very specific, the disability examiner has wide discretion in gathering and evaluating medical evidence. SSA internal guidelines governing CDIs only advise that the only question to be resolved during review is "whether an individual is currently disabled" and that in determining that, the examiner is to "consider the original impairments and any new conditions."[54]

[53] Program Operations Manual System (POMS) § D12027.
[54] Id.

VI. IMPACT OF CDI REVIEWS ON BENEFICIARIES

Predictably, the tremendous increase in continuing disability investigations conducted under a troubled system has lengthened delays, increased confusion over the standards for reviewing disability, and regrettably, led to the termination of benefits for thousands of severely disabled persons who deserve to remain in the program.

Statistics provided by the Social Security Administration show that between March, 1981 and April, 1982, state DDSs reviewed 405,000 cases and nearly half of the reviewed beneficiaries—191,000—were terminated from the program. The rate of terminations is more than double that predicted by the SSA (20 percent) in its own estimates of ineligible beneficiaries.[55]

Of the 50 percent who appeal this termination of benefits, 67 percent were subsequently reinstated to the program after hearings before ALJs who found that these individuals are still severely disabled and eligible for the program.[56]

The wait for eventual reinstatement of benefits can take from nine to twelve months, and as discussed below, these delays and backlogs are increasing. As a result, severely disabled persons who are unjustly terminated from the program must go without needed disability benefits for lengthy periods even though they have worked previously and specifically paid for the right to receive these benefits.

This costly and wasteful effort of removing and subsequently reinstating severely disabled persons caused an approximate 36,000 workers and their dependents to go without benefits for months on end (during the period March, 1981 through April, 1982). The human costs have reached tragic proportions, and the outcry from across the nation—from beneficiaries, psychiatrists, physicians, social workers, lawyers—has unveiled a plethora of erroneous decisions and a nightmarish impact.

At least 8 known suicides have been attributed to disability decisions under this program.[57] Press reports repeatedly have reflected the horror of individual lives disrupted and destroyed by erroneous decisions, and have documented well that these errors are too common and too tragic to ever be considered excusable.[58]

At our own hearing, Mrs. Ethel Kage of Reed City, Michigan, testified with clarity and great eloquence about the tragic toll an erroneous SSA disability decision levied on her severely disabled husband.

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[55] Supra fn. 6.
[56] Supra fn. 7.
[57] Based on interviews conducted by Subcommittee staff.
[58] Hearing record, pp. 468–508.

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Richard Kage had been diabetic since age 12, but as his diabetes worsened, he had become blind in one eye as a result. He had other vascular complications from his diabetes, which eventually resulted in a blood clot in his brain which blocked his visual centers, leaving him with residual vision in only one-half of his other eye.

At that point, Mr. Kage was no longer able to continue in his job as a surveyor for the Michigan State Road Commission. He tried numerous other jobs, but because of his blindness, he was unable to find work he could do. He was able to get around his house, but it was impossible for him to drive, and he gave up his driver's license after the stroke. It was at that time, in 1974, that he entered the disability program, based on his severe insulin-dependent diabetes, his blindness, and his cardiovascular problems. Disability benefits were awarded to Mr. Kage, as well as to his dependent wife and their two children.

On April 6, 1981, the state disability determination unit notified Mr. Kage that his disability eligibility was under review. Mrs. Kage described Mr. Kage's reaction to that letter:

> When we received the Notice of Review, it was quite a shocking affair for Dick. I arrived home from work, and he was in a very agitated state. He thought everything, you know, was going down the drain, that the plug had been pulled out. He didn't know how we would survive.
>
> I think our first thought at that time is what kind of system is this that can allow something like this to happen? If we had the system for 25 years or so, why all of a sudden are we going through this massive review? Isn't this something that should have been done on a continuing basis?[59]

On April 13, Mr. and Mrs. Kage returned an enclosed information form to the disability agency and listed the names of the physician and ophthalmologist who had submitted medical reports in support of Mr. Kage's initial application and who had continued to treat him.[60]

The state disability agency then requested information from Mr. Kage's two doctors, both of whom promptly submitted information reciting Mr. Kage's original and continued impairments. The physician's report indicated that in the 7½ years since Mr. Kage started to receive benefits, his condition had actually deteriorated, and concluded that Mr. Kage was seriously handicapped, totally unemployable and disabled. Similarly, his ophthalmologist, who had performed surgery on one of Mr. Kage's eyes, submitted the results of his most recent examination of Mr. Kage.[61]

Nonetheless, Mr. Kage was referred to another ophthalmologist, 45 miles from his home, for a consultative examination on May 5. After a 15-minute eye field examination, the consultative ophthalmologist issued a report which noted that Mr. Kage could detect some motion in his right eye and concluded: "The patient is almost blind for all practical purposes but the presence of central vision in

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[59] Testimony of Mrs. Ethel Kage, Reed City, Michigan, hearing record p. 61.
[60] Available in Subcommittee files.
[61] Available in Subcommittee files.

the right eye gives him some reprieve from being a total cripple."[62]

No consultative examination was scheduled to obtain medical information on Mr. Kage's diabetes and cardiovascular impairments.

On May 14, 1981, the state agency notified the Kages that based on his treating physician's reports, it had been found that: ". . . you have a severe impairment caused by your visual impairment; however, it is found that you do retain sufficient capacity for light work activity requiring limited visual efficiency."[63] His disability benefits were terminated effective July 30, 1981.

Mr. Kage's two treating physicians were shocked and disturbed by the decision, and both offered additional information to Social Security on Mr. Kage's impairments. Dr. Strong, Mr. Kage's ophthalmologist, wrote a letter to the agency on June 12 again stating that "extensive pan retinal photocoagulation because of neovascular diabetic retinopathy" left Mr. Kage in "no condition for employment."[64] Dr. Strong again enclosed copies of visual charts on Mr. Kage's condition.

Dr. Vining, the other physician, called the state agency to protest the decision and offered to provide any additional necessary information.

Mrs. Kage described her contacts with the state disability agency and her frustration in seeking information from the agency. On August 10, Mrs. Kage sent in a written request for reconsideration of the termination decision. On September 25, she sent in additional reports from her husband's two treating physicians.

Having received no acknowledgement of her request, Mrs. Kage called the local Social Security office on October 8 to check on its status. Though she was told that a check for the file would be made and that she would be advised of the current status, she received no information from that office. Mrs. Kage called back a week later, and was told that her husband's file had been located in Baltimore and was enroute.

On October 30, Mrs. Kage had heard nothing from Social Security and again called regarding the status of the redetermination request. She was told that Mr. Kage's file was held up by the computer process in Baltimore.

Mrs. Kage testified further:

> All this time, we had been without any income. And at that time, Dick had been in the hospital. He had a toe that was gangrenous, and they thought it was going to have to come off. Fortunately, antibiotics stopped it at that time, so he only spent a week's stay in there.
>
> I sent that additional information, also, to the Social Security Administration. By November the 5th, I still had heard nothing. That is when I contacted Senator Levin and our other representatives for our district.
>
> On November the 25th then, we received another Notice of Disability Examination Form from the Disability Determination in Traverse City, setting another appointment

[62] Available in Subcommittee files.
[63] Available in Subcommittee files.
[64] Available in Subcommittee files.

with the same doctor in Mt. Pleasant for another visual exam that we had gone through before.[65]

She continued:

> Two days after that, Dick died.
>
> He took sick on Thanksgiving evening, and by 7:00 o'clock the next day he was dead. He had two massive heart attacks.
>
> I talked to the doctor [Dr. Vining] on Monday who performed the autopsy. He gave me the results . . . And he said at that time that the pressures that he sustained, the stress from this cessation of benefits, was definitely a contributing factor to his death.
>
> I called the Disability Determination Service to tell them that we would not be keeping the appointment and why, that Dick had died. And they made no comment whatsoever. They just said, "All right," and hung up.
>
> I think I would like to speak to that, because any time people are working with people and trying to be helping people, I think there could be a little compassion shown.
>
> Through Senator Levin's work on our behalf, we have received a letter from him and a phone call at the end of January saying that our Social Security disability was being reinstated from the time that it was cut off until Dick's death. This was on January 29th. We received nothing from the Social Security Disability Determination or anyone else until April 5th.
>
> Senator COHEN. Of this year?
>
> Ms. KAGE. Of this year.
>
> Never did we receive anything that they received the file, that they were working on the file, other than my phone calls to Mt. Pleasant, never anything that was instigated on their part, no correspondence saying "We have received your request and it is being processed." We got nothing.[66]

Senator Levin had this reaction to a letter Dr. Vining later wrote the state disability determination agency regarding the cessation of Mr. Kage's benefits and his death:

> What happened in your husband's case now, according to the doctor, it seems to me, is overwhelming and I want to just read that line, although it hurts. I'm not a doctor, but let me read what the doctor said, and doctors don't say things like this very easily. He says, after your husband was notified that he was now capable of working and in the process of attempting to do so, and under the stress created by the termination of his disabilty benefits, Mr. Kage had an acute myocardial infarction and died.
>
> Now, I've seen a lot of doctors in a lot of courts and know doctors do avoid testimony about causation. They do not readily reach those kinds of conclusions. This is a con-

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[65] Hearing record, pp. 62-63.
[66] Hearing record, p. 63.

> clusion which the doctor wrote in a letter to the Disability Determination Service, which should be made part of the record as to exactly what it is we're talking about in one case. Multiply this by thousands of cases and we have an added dimension: but in one very real case, most real to you, you're familiar with it, we have a doctor who said that under the stress created by the termination of his disability benefits and attempting to work because he was totally incapable, he had a heart attack and died.[67]

Later, Mrs. Kage elaborated on the impact of the loss of benefits on the Kage family:

> And one small item about the loss of benefits during the appeal process, the people who are on disability aren't making that much money that you can set money aside, that you have any kind of savings or income to support you over that time limit. So when your disability is discontinued, you're at the edge. I mean, you have nothing to fall back on to hold you over those months that it takes, and I think that is never taken into consideration. There is no leeway. When you're at the end, you're at the end, period.[68]

To this Senator Levin added the following:

> . . . you may then appeal, and most of the people who are wise enough or informed enough or whatever to appeal, or are alive to appeal, are going to win. But during that nine to 12-month period of that appeal, they're going to lose and they're going to lose hard because they're going to be cut off the rolls and benefits will not be paid during that period of appeal, although two-thirds of the people appealing are going to win.
>
> I can't get that fact out of my craw. No government, it seems to me, should tolerate that kind of injustice. It's a massive injustice.[69]

Unfortunately, Mrs. Kage's experience has been repeated by thousands of other families who have been dropped from the program. Additional examples of the tragic impact of erroneous benefit terminations are well documented in the Subcommittee hearing record accompanying this report.[70] Other testimony at the hearing and written statements submitted to the Subcommittee detail further the experience of other severely disabled people who lost benefits.[71] The mentally disabled have been especially hard hit by the review process, according to written testimony submitted by the American Psychiatric Association, the Mental Health Law Project, and the National Mental Health Association. An extensive study on the impact of the disability terminations on the disabled and on strained state and local resources was conducted by the City of New York; it was concluded that large numbers of seriously ill and

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[67] Hearing record, p. 66.
[68] Hearing record, p. 67.
[69] Hearing record, p. 66.
[70] Supra fn. 5.
[71] Id., supra fn. 58.

unemployable disabled people were being discharged from the program, only to turn to state assistance programs for money for survival.[72]

Faced with these tragically anomalous results, the Subcommittee sought to find out why benefits to severely disabled people were being terminated.

[72] Hearing record, pp. 298–324.

VII. CDI REVIEWS—MANAGEMENT CRISIS

A. Workloads

Workload levels in both state DDS offices and the ALJ hearings and appeals level have increased since the onset of the recent CDI cases and questions regarding the accuracy and timeliness of CDI decisions have been raised repeatedly.

1. State agency workloads

Statistics from the Social Security Administration show that between fiscal year 1974 and fiscal year 1980, state DDSs received between 21,405 to 30,827 cases per quarter for review. Yet during the third quarter of fiscal year 1981 when the accelerated reviews commenced, state DDSs received 99,330 cases for review. During the fourth quarter of 1981, that number had risen to 141,992. For the second quarter of 1982, the SSA sent the states 149,824 cases to be reviewed—if this trend continues, 600,000 cases would be sent to the states during fiscal year 1982.[73]

An analysis by the General Accounting Office illustrates the impact of this tremendous increase in cases on state workloads. Between December 1980 and 1981, the pending national backlog in CDI cases jumped by 368.9 percent, from 25,492 to 119,515.[74]

Perhaps the best description of the impact of CDI cases on a state DDS agency came in testimony from Herbert Brown, the Administrator of the Tennessee Disability Determination Section in Nashville,[75] Mr. Brown was advised by phone on March 5, 1981, that within two weeks, his agency would be sent 2,500 new CDI cases for review by July 1, 1981, and another 2,500 by September 30, 1981. His office was also advised that during fiscal year 1982, 1983, and 1984, the SSA would send an additional 11,179, 19,767, and 30,896, respectively—a ten-fold increase from 1980 CDI workload.[76] Until 1981, his office had only processed 3,000 CDI cases each year. Yet, during fiscal year 1981, the Tennessee Disability office received 8,840 CDI cases and processed 5,891 of them.

The impact of these increases—coupled with the advent of other 1980 amendment requirements (e.g., personalized denial letters)—meant devastation for a state agency which had been under-staffed for the previous four years, and which was under a state hiring freeze at the time.

Having been advised by the SSA that CDI case reviews were to be given high priority, but not having any new staff to assign, Mr.

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[73] Supra fn. 6.

[74] Congressional staff briefing by General Accounting Office, May 5, 1982.

[75] Testimony of Herbert Brown, Administrator, Tennessee Disability Determination Section, Nashville, Tennessee, hearing record, pp. 120-122.

[76] Id. at 120.

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Brown shifted staff and work to try to accommodate the workload. But this was not enough:

> Mr. BROWN. Within another six months, the pending workload had increased from 7,473 in March to 14,421 in September, 1981 and initial case processing time had increased from 35 days to 60 days. High caseloads and implementing personalized denial letters so adversely affected our performance that for three consecutive quarters, our processing time exceeded the maximum acceptable according to regulation which brought Social Security on our back because of poor performance. . . .[77]

In order to keep the agency's non-CDI caseload at an acceptable level, the Tennessee office had to "stack" incoming CDI claims, i.e. 4,000 cases have been logged into the case control system but no action has been taken on them.[78] The agency was able to secure 50 additional positions in July, 1981, but the latest request for 90 additional positions was reduced to 25 and was not filled until July, 1982.

But without sufficient staff, the agency will be unable to process the CDI cases in a timely fashion. Mr. Brown stated: "Social Security is well aware of our dilemma, but the cases continue to pour in."[79]

The choice between processing initial cases and processing CDI cases, but not being able to do both, caused the efficiency of the agency to suffer dramatically, according to Mr. Brown's testimony:

> Despite the regulations, it does appear that Social Security could have accepted some responsibility for 'accelerating' the CDI process in March, 1981 which forced us into an unacceptable level of performance. They sent us cases we were unprepared for, then 'gigged' us when it adversely affected our performance. Morale during the last 12 months has been the 'pits.' Much of the staff had been working overtime from November 1979 to October, 1981 and were literally burned-out just trying to survive.[80]

Nor is the experience in Tennessee unique. Social Security Administration statistics show that the state of California experienced a staggering increase in the state agency workload during fiscal year 1981 and the first two quarters of fiscal year 1982. At the end of the first quarter fiscal year 1981, California had 3,657 CDIs pending; but by the end of the 4th quarter fiscal year 1982, pending CDIs totaled 13,042. For the same period, pending CDIs in New Jersey also rose from 958 to 7,552.[81]

Certainly, Mrs. Kage's experience in Michigan is a disturbing illustration of what these delays actually mean to a beneficiary who loses benefits and then must endure the long wait for state reconsideration of the decision. Despite repeated inquiries from Mrs. Kage and congressional intervention on her behalf, it took the

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[77] Id. at 121.
[78] Id.
[79] Id. at 122.
[80] Id.
[81] Supra fn. 14, p. 28, and Appendix III.

state agency a full eight months to reach a new decision, where benefits were restored. Other examples of the lengthy state delays and their disruptive impact are included in other testimony.[82]

2. Hearings and appeals workloads

ALJ hearing backlogs have been long-standing and have now reached crisis proportions, according to a recent House Ways and Means report.[83]

During fiscal years 1975 and 1976, the average length of time a case was pending before the ALJ was over 200 days.[84] In response to that backlog, Congress increased the number of ALJs and support staff, and the backlog was gradually reduced.

Currently, the backlog is again rising, threatening to surpass the 1975 crisis level. In fiscal year 1975, the average number of pending cases per ALJ was 173; although it dropped to 129 in fiscal year 1978, it has risen steadily since. From March, 1981 (after the accelerated CDI reviews) to October 1981, it has been at over 180 cases per ALJ.[85]

A backlog of 129,551 cases was pending for a hearing as of August 1981, and it is projected that this figure will increase to 200,000 by 1983. Cases received for hearing totaled 275,000 in fiscal year 1981, but are expected to rise to 340,000 in FY 1982 and to 416,000 in 1983.[86]

Unreasonable delays in hearing cases have led various federal circuit and district courts to mandate more reasonable time limits for hearing cases. A district court in Kentucky had imposed a 90-day limit at a time when the average wait was 200 days.[87] Saying that a 90-day limit was impossible to meet, the SSA proposed in August, 1980, a 165-day limit instead.

But by June, 1981, the SSA filed a brief requesting to change its proposed 165-day limit to 180 days, contending that hearing resources had continued to be outstripped by hearing requests.[88] As of October, 1981, approximately one-third of the hearing cases were not being processed within 165 days.[89]

Louis Hays, Associate Commissioner for Hearings and Appeals at Social Security, has testified that the projected increase in hearing requests will skyrocket due to disability benefit terminations resulting from the SSA's accelerated CDI reviews.[90] In an attempt to meet that increase, an additional 100 ALJ positions are planned for fiscal year 1982, but to date increasing delays and backlogs have not been stemmed, and as of March, 1982, only 52 additional ALJs had been hired.[91]

Testifying on behalf of the Association of Administrative Law Judges in the Department of Health and Human Services, Judge

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[82] Supra fn. 5.
[83] House Subcommittee on Social Security, Committee on Ways and Means, "Social Security Hearings and Appeals: Pending Problems and Proposed Solutions," October 27, 1981.
[84] Id. at 3.
[85] Id.
[86] Id.
[87] Id. at 7, and 36.
[88] Id.
[89] Id. at 8.
[90] Id. at 46.
[91] Supra fn. 14, p. 29.

Francis O'Byrne of Chicago described how the increased volume of cases affected his office and his own work:

> About five years ago, the OHS (Office of Hearings and Appeals) let the ALJs know that the "production" goal was 26 cases per month per ALJ. Now we are advised that the goal is 40 to 45 cases per month. Most judges have met the prior goal and now average about 30 decisions per month. . . . I issued about 31 decisions per month in 1981. During the first four months of 1982, I have averaged 41 dispositions per month. In April, I closed 59 cases.[92]

But he explained further:

> I cannot maintain this level of average monthly decisions for any extended period of time. In order to close 166 cases through April of 1982, I have come to the office early, have worked on Saturday, traveled to out of state hearing sites on my own time, and worked a 79-hour week on a hearing trip to Wisconsin. Judges all over the country have been making this extra effort because we wish to accommodate the claimants waiting for a hearing . . . The speed at which the acceleration process has been implemented has caused needless misery across the land. There are not enough ALJs on duty to quickly cure the problem. The problem must be cured at its source.[93]

3. Impact on quality of decisionmaking

Questions have been raised about the impact of this increased workload on the quality of decisions at all levels. Judge O'Byrne addressed this issue this way:

> Meeting the heavy and ever increasing case load has not been without cost. My decisional quality is not as good as it once was. I do not have time to polish decisions. Instead of striving for good to very good decisions, I have to settle for good enough. . . . There is less time to spend on each decision. I am sure the processing time on my cases has become longer and that the period of time between the hearing request and the hearing has been extended.[94]

However, the impact on the quality of state agency decisions has raised the most serious concern. Judge O'Byrne described his own experience:

> For some months now about 25 per cent of my pending cases have been cessation cases. I estimate that about 20 to 25 per cent of these cessation determinations will be correct and almost all of these correct cessation determinations will involve physical impairment cases. I estimate that 10 per cent or less of the mental impairment cessations will prove to be correct. . . . In a much higher number of cases, I do not understand how any reasonable person following the Act, the Regulations and the Social

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[92] Hearing record, p. 137.
[93] Id.
[94] Id. at 141-142.

> Security Rulings could have found a claimant's disability to have ceased.[95]

Judge O'Byrne's experience is not unique. Other administrative law judges have raised similar concerns. Judge Chester Shatz, New England Director of the Association of ALJs, put it this way:

> With regard to the speed in which such review of termination cases are performed, we have found in a vast majority of the cases that there has been poor development of the medical record at the state agency level. In all fairness to the state agencies, we believe that such poor development is due in large part to an extremly large state agency workload, under-staffing of the state agencies, and arbitrary time constraints imposed on the state agencies for processing cases. . . . The Administrative Law Judges often feel that the hearing level has become the "dumping ground" for the hurried state agency process.[96]

In a final observation, Judge O'Byrne again noted that ALJs believe they are receiving a significant number of cases that would not have been cessations if the state agencies had more staff and more time to develop medical evidence. He concluded: "The state agency employers and examiners are as much victims of the present system as is the OHA."[97]

B. Poor Development of Medical Evidence

At the request of Congress, the General Accounting Office (GAO) began a review in January, 1982 of the SSA's policies and practices in conducting the disability investigations. After meeting with state officials and disability examiners, administrative law judges and SSA offices, the GAO identified a number of issues and problems with the current CDI process. According to its report to the Subcommittee, the principle concern which guided the GAO inquiry was this:

> . . . many of those losing their disability benefits have been on the SSA rolls several years, still have what we would all consider to be severe impairments, and have experienced little or no medical improvement. This raises questions about how and why these people are being terminated, and the fairness of SSA's decisions.[98]

The principal cause for this tragically ironic outcome is the poor development and evaluation of medical evidence in determining disability. The GAO's report and other testimony and evidence corroborate this analysis. The discussion which follows describes the specific problems in the development and evaluation of the medical evidence.

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[95] Id. at 138.
[96] Written statement from Judge Chester Shatz, New England Director of the Association of Administrative Law Judges, Department of Health and Human Services, hearing record p. 390.
[97] Id. at 141.
[98] Supra fn. 9.

1. Cases treated like initial applications

The GAO found—and many others have concurred[99]—that one crucial aspect of state agency treatment of CDI cases is the practice of treating them as if they were new claims. The SSA has issued no specific development guidance for these cases, but rather has simply instructed the state agencies to determine eligibility in generally the same manner as initial claims.[100]

As a result, state agencies are gathering only current evidence—usually no more than two or three months old—and relying on it alone to determine if the beneficiary's disability continues. As a consequence, the person's complete medical history is often ignored in the disability determination. The effects of this practice were described by the GAO this way:

> While the need for current evidence is obvious, we also believe there is a need for a historical medical perspective in these ACDI cases. Many of these individuals coming under review have been receiving benefits for several years. To base a decision on only the recent examination—often a purchased consultative examination—could give a false reading of that person's condition. This is especially true for those impairments subject to fluctuation or periodic remission, such as mental impairments.[101]

The American Psychiatric Association, which represents over 27,000 psychiatrists, made this comment on this practice:

> What we find disturbing about the CDI process is not only the apparent disregard of the special and complex nature of mental illness in this initial data-gathering, but also that the case record of a current SSDI recipient is wholly discounted in the CDI process. We understand from SSA that when a CDI is undertaken, evidence must be gathered de novo, as if no prior history of disability existed. We find the disregard of an existing medical history to stand in clear opposition to procedures assuring a full and sound medical evaluation. Its redevelopment, upon notice of a CDI, places an undue hardship upon the patient and his or her treating physician, if one exists.[102]

Finally, the GAO also concluded that this practice of treating disability "reviews" as if they were new cases results in incomplete medical information at the state level. It is also one of the primary reasons treating physicians are not contacted or their information is not considered in the disability decision—two other frequent and serious complaints about the CDI process.[103] This approach also helps explain the high consultative examination rate in CDIs and the increased reliance on consultative exams in these reviews (to be discussed in greater detail).[104]

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[99] Supra fn. 5.
[100] Supra fn. 9, p. 10.
[101] Id. at 10–11.
[102] Hearing record, p. 327.
[103] Testimony of Ethel Kage and Jonathan Stein, hearing record, pp. 64 and 72–74, respectively.
[104] See § (VII)(B)(4) which follows at p. 33.

2. No showing of medical improvement

As a result of the SSA's treatment of CDI cases as if they were initial applications, many beneficiaries whose medical conditions have not improved, or have worsened since they began receiving benefits, have been found "no longer disabled" and have been terminated from the program. SSA policy explicitly forbids any consideration of whether the beneficiary's medical condition has actually improved.

From 1969 to 1976, the SSA operated under the principle that terminations from the disability insurance program had to be based on evidence which demonstrated medical improvement. In effect, all initial disability decisions were presumed to be correct, and as a result the SSA had no way of terminating people from the program who had been erroneously allowed there.

SSA has since changed this policy, informally in 1977, and by formal regulation in 1980.[105] However, rather than requiring a showing of medical improvement or of an initial error or fraud before benefit terminations, the SSA simply eliminated the medical improvement requirement altogether.

Even in the face of several federal court decisions to the contrary,[106] the SSA specifically and emphatically reaffirmed this policy in a January, 1981, Social Security Ruling (SSR 86-6) that "it is not necessary to show that the individual's medical condition has 'improved' since the prior determination."[107]

The effect of this change is that the prior SSA finding of disability not only carries no presumption of continuing disability, but is a fact absolutely disregarded in the CDI reviews.

This practice concurs with the SSA's treatment of CDI cases as if they were new applications. It also adds much to the confusion surrounding disability reviews since no indication is ever given to the beneficiary or the treating physician that reiterating the existence of the original disability condition is not only insufficient, but irrelevant under current SSA policy.

The GAO singled out this policy—no required showing of medical improvement—as accounting for the large percentage of benefit terminations of severely disabled persons whose disability conditions remain unimproved.[108]

3. Inadequate notice to beneficiaries

Beneficiaries are put in a particularly disadvantageous position in developing proof of their continuing disability. The initial notice the person receives simply advises that the person's continuing eligibility is being reviewed, and that he or she may be required to submit to a consultative exam. A four-page form is also included which requests information on current treating physicians and general information on the person's ability to work.[109]

Nothing in the form, or the initial notice, even hints that the person's disability is being evaluated as if the claimant were just

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[105] 45 CFR 55566 (1980).
[106] *Finegan* v. *Matthews*, 641 F.2d 1340 (9th Con. 1981).
[107] Social Security Ruling (SSR 86-6)
[108] Supra fn. 9, p. 17.
[109] Available in Subcommittee files.

now applying for benefits. Nothing in the notice reveals that the previous SSA determination of disability carries no presumption of continuing disability. Nothing alerts the person to the fact that he or she must start all over to prove his or her disability and that nothing currently on file at the SSA will be considered in the decision. Nothing urges the person to request that his or her treating physician submit a complete medical history, rather than simply a current update of medical conditions.

After the state agency has reached a decision to terminate benefits, the notice to the beneficiary affords only 10 days for the person to gather and submit medical evidence before the decision becomes final and benefits are terminated. Even then nothing in the notice indicates that the decision made was not a "review" at all, but rather a new determination based on current medical reports—and, as will be discussed, one based on more stringent and inconsistent interpretations of eligibility criteria.

The inadequacy of the current notice to beneficiaries is well illustrated in this exchange between Senator Cohen and Mrs. Kage:

> Senator COHEN. Were you under the impression that you would have to prove your husband's disability again?
>
> Mrs. KAGE. No. That was never stated.
>
> In fact, right up to this point, until I heard it today, I was not aware of that fact.
>
> Senator COHEN. That they would disregard the prior condition?
>
> Mrs. KAGE. Right.
>
> And I think when we're talking about a review, we're talking about a misnomer, because a review is on something that has already been. What we're talking about here is John Doe walking in off the street is doing the same thing as a person who has been on disability, as Dick was for seven years. And they have completely erased everything that happened prior.
>
> Senator COHEN. Well, that's exactly why I raised that issue, because most people, when the SSA says your case in under review, normally would assume—well, from where?—from where you were, to see whether your case has improved or deteriorated, and start from there.
>
> In fact, the practice has been to just ignore what the disability was, ignore the past medical records, and take into account only from the moment where the claimant or your husband was examined by the doctor.
>
> Mrs. KAGE. I am saying that up to that time I had not heard about that.
>
> Senator COHEN. That's why I think it's so important that the letter to you be very clear about what you're up against, and what you've got to do is to prove your case. The burden is going to be upon you, and you'd better come prepared. And that letter doesn't do it.[110]

The impact of the current notice procedures lead to this observation by Senator Levin:

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[110] Hearing record, pp. 60–61.

> Senator LEVIN. It keeps you in the dark, as you have just said. It treats you like a child, to your own detriment, because ultimately what's happening to you is that you're in the process of being cut off the rolls. You're to be considered no longer disabled, in a vast number of cases without any adequate medical examination. That was what was happening to you. What's also happening is that you're going to have to prove all over again that you're disabled, and you're not told that, as Senator Cohen has pointed out.[111]

Few beneficiaries at this stage of the determination process have sought assistance in determining exactly what information is most essential for the state agency to consider, especially in view of the inadequacy of the notices sent by the SSA. The mentally ill are particularly unable to provide needed information on their impairment. In a statement whose content was often repeated by others, the American Psychiatric Association describes the situation in detail:

> Many of the mentally ill under psychiatric care . . . are unable to understand that their only source of income is being threatened. They often do not understand the complexity of the forms, or the necessity of such forms being completed. They either neglect to return the forms or to complete them adequately and, as a direct result of their disabilities, lose their monthly support. . . . Moreover, given the nature of mental illness itself, it is often inappropriate if not impossible to receive an accurate self-evaluation . . . it is the very nature of the illness which causes a patient to deny or distort the medical significance of such illness.[112]

4. Too much reliance on consultative examinations

The use of consultative examinations has become increasingly common in the disability determination process. Yet, many serious criticisms of the quality and the role of consultative examinations persist. Even more questions have been raised by the tremendous reliance placed on consultative examinations during the CDI process.

In recent years, the overall rate of consultative examinations purchased by the SSA has increased significantly—from 19.7 per cent to 40 per cent in 1981.[113] However, of most serious concern is this: for CDI reviews, the SSA expects that 75 per cent of the cases reviewed will have had at least one consultative examination.[114]

These examinations are quite costly; SSA expenditures for them totalled $137 million in fiscal year 1981 alone.[115] But federal controls over when consultative examinations are purchased and the quality of the examinations have been virtually non-existent.

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[111] Hearing record, p. 65.
[112] Hearing record, p. 326.
[113] House Subcommittee on Social Security, Committee on Ways and Means, Volume Providers of Medical Examinations for The Social Security Disability Program, Hearing Record, September 13, 1981, p. 5.
[114] Id. at p. 5.
[115] Id. at 8.

As indicated earlier, in 1977, SSA program officials seeking additional funds for more consultative examinations found it increasingly difficult to demonstrate such a need. As a result, the SSA surveyed state DDS agencies to assess the need for consultative exams. That survey revealed, however, that evidence from treating physicians was not pursued adequately, and consultative examinations were purchased unnecessarily, and consultative examinations reports were often inadequate for state agency use. A look at the relationship between consultative examinations and the accuracy of disability decisions also revealed that the accuracy rate was the same with and without consultative examinations. Despite these findings, no remedial action was proposed or taken by the SSA.[116]

Similarly, a 1978 SSA study and a 1979 GAO report found that SSA funds were wasted on unnecessarily, incomplete, or inadequate medical reports from consultative examinations. The results of some state agency studies showed that 68 per cent of reports from consultative examinations were inadequate. In fact, many of the reports were so inadequate that a disability decision could not be made without further information.[117]

SSA has developed no mechanism for monitoring the number or quality of consultative examinations. As recently as September, 1981, the House Ways and Means Committee held a hearing on poor management of the consultative examination system. It focused primarily on "volume providers"—groups of physicians, or clinics who specialize in doing SSA consultative examinations. Criticisms had been leveled that some of these volume providers conduct assembly-line examinations of claimants and issue inadequate medical reports, as a result. In fact, part of the impetus for the hearing was the indictment of several doctors on federal fraud charges for submitting payment vouchers for examinations which were never conducted, among other questionable practices.[118]

Yet, as noted earlier, the increased CDIs have also led to a skyrocketing rate of consultative examinations. Some have attributed this increase to two factors: first, the rush to develop medical evidence quickly due to the enormous onslaught of cases, and, second, the state agencies' sole reliance on current medical evidence to the exclusion of the full medical history.[119]

The experience in Pennsylvania supports this analysis:

> The high volume of cases causes adjudicators to cut corners and not seek such [treating physician] evidence. Thus Pennsylvania adjudicators told a client . . . who is 60 years old and a World War II veteran, whose multiple disabilities include severe arthritis, angina, high blood pressure, diabetes, and a psychiatric nervous condition, that they would not even write to his two treating VA hospital doctors, an neuropsychiatrist and an orthopedist because as a matter of policy they could not wait for the VA to respond because they would not meet their processing

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[116] Supra fn. 40, p. 7.
[117] Id. at pp. 11-12.
[118] House Subcommittee on Social Security and Oversight, Committee on Ways and Means, "Volume Providers of Medical Examinations for Social Security Disability Cases," September 18, 1981.
[119] Statement of Judge Francis O'Byrne, hearing record pp. 138-139.

> time goals. In addition, evidence more than three months old is not considered "current" in Pennsylvania and is deemed irrelevant, something which would shock any professional physician.[120]

The fact remains, however, that despite POMS guidelines which clearly and emphatically limit the instances when consultative examinations are to be purchased, an excessive number of examinations are being bought as a part of the CDI process.

Complaints about the thoroughness of the examinations and the adequacy of the reports are rampant. The most common complaint from beneficiaries and their representatives is that the examinations are cursory, with little or no discussion of the person's medical history.[121] In some cases, beneficiaries are sent to physicians who are not specialized in the person's particular ailment.[122] Still others report that beneficiaries never actually see a physician, but are treated and examined by technicians who later secure a physician's signature on the examination report.[123]

Under these circumstances, the quality of the resulting examination reports is highly questionable. There is evidence that questions about the quality of the reports exist at the ALJ level. According to written testimony:

> In some areas of the country, the administrative law judges simply ignore the consultative reports because their experience with the particular provider(s) has taught them that their reports are useless and unreliable. Given the current abuses of some consultative physicians, this is as it should be. However, it is critical that the cost implications be recognized. Because the SSA has failed to regulate consultative physicians, it is throwing money away just so that it can assure that there is a piece of paper in the file. If the reports are so useless as to be ignored, they should not be purchased.[124]

These and similar observations are too frequent and too serious to be ignored. This is particularly true in view of evidence that in determining continuing eligibility, state agencies accord greater weight to consultative examination reports then they do reports from the beneficiary's own treating physician.[125]

When the SSA sends a beneficiary to a consultative examination, the SSA has informed the physician exactly what information it needs and precisely specifies the needed format so that comparison to the SSA Listing of Impairments can be easily made. On the contrary, when information from treating physicians is sought, not only is this specificity in direction lacking, but the treating physician is also given no notice that the person's case is being evaluated as if it were a new case (as described earlier).

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[120] Hearing record, p. 100.
[121] See generally, supra fn. 5.
[122] Supra fn. 103.
[123] Supra fn. 40.
[124] Written statement by Eileen Sweeney, National Senior Citizens Law Center, hearing record p. 268.
[125] Testimony of Ethel Kage, Kathleen Grover, and Jonathan Stein, hearing record pp. 64, 69, and 72–74.

The result is not surprising and was succinctly described this way by one witness:

> Thus initial reports from treating doctors often lack the required specificity because the SSA and the DD agency hide the ball from them. When caring and conscientious doctors summarily conclude what is often obvious even to a layman, that a person is totally disabled, the state DD agency as a matter of SSA policy ignores the report as conclusory and fails to follow-up with requests for more detail.[126]

This result is especially troubling in view of federal court decisions that special consideration must be given to reports from treating physicians in reaching disability determinations.[127]

Mrs. Kage's testimony raised similar concerns about the treatment of treating physician reports and the quality of consultative examinations:

> Mrs. KAGE. It's interesting, I think, to note that the same doctors who supported our disability claim at [the time Mr. Kage was initially found disabled]—when the reconsideration hearing came up, those same doctors were completely ignored, and apparently their reports were not taken into consideration at all.
>
> In fact, Dr. Vining, who was the internist and diabetic specialist, who had been our doctor for some 17 to 20 years, states in his letter, which was written after Dick died:
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> "I believe that the disability determination service standards for disability are erroneous, false, and misleading.
>
> "When a physician who had been entirely in charge of a patient's medical care states that a patient is totally disabled, it seems totally unrealistic and completely ridiculous for any physician seeing him one time on a brief examination to countermand a statement of disability on the part of an experienced physician on the basis of a single visual field determination. On Mr. Kage's residual vision, he was claimed to be no longer disabled and was directed to return to work by the Disability Determination Service." [128]

Mrs. Kage aptly described the essential question raised by this approach:

> I guess the main question I have is why they disregard the physician who has treated someone for X number of years and two experienced physicians, very well qualified physicians, specialists in their field, why these are completely ignored and the doctor who sees a person for 15

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[126] Hearing record, p. 101.

[127] See generally, *Bustien* v. *Califano*, 572 F.2d 908, 912 (2d Cir. 1978); *Hephner* v. *Mathews*, 574 F.2d 359, 362 (6th Cir. 1978); *Allen* v. *Weinberger*, 552 F.2d 781, 786 (7th Cir. 1977); *Ross* v. *Califano*, 602 F.2d 55, 58 (3d Cir. 1979).

[128] Hearing record, pp. 59–60.

> minutes can make the determination that he is no longer disabled, and everything rests on that doctor. . . . it's been our experience that the family physicians, even though they were specialists in their field, were completely ignored and a 15-minute exam by the government physician is the one that is considered.[129]

There is a critical need for accurate and complete medical information in disability determinations. Information from treating physicians, supplemented by consultative physician reports where necessary, form the core of this medical evidence. Yet existing practices and guidelines have proved inadequate in ensuring that information from treating physicians is adequately pursued and that consultative examinations are ordered only when absolutely necessary. Nor has the SSA ensured that evaluation of the resulting information is conducted in a way which gives full weight to the treating physician's knowledge of the beneficiary's full medical history.[130]

5. No opportunity for face-to-face contact at state level

One difference in making disability decisions at the state versus the ALJ level is that the state decision is made without any face-to-face contact with the beneficiary. This is considered one of the key reasons for the discrepancy between state and ALJ allowance rates.[131]

The need for and usefulness of face-to-face contact at the early level of decision making is one which was acknowledged and supported by the Social Security Administration at the Subcommittee's hearing, despite this assessment by Louis Hays, of the Office of Hearings and Appeals:

> While the face-to-face process certainly can be viewed as an improvement, in the sense that it gives a complete picture of the claimant . . . while I think that's an important thing to add to the reconsideration process, at least in these termination cases, it also does have an additional element of the subjectivity, having the person before you, raising all the sympathies that we all feel, as compassionate human beings, to our fellow man.[132]

Under current procedure, the reconsideration decision is simply a paper review of the state's earlier determination, and in 85 per cent of the cases the initial decision is affirmed.[133]

The need for some face-to-face contact with the beneficiary before benefits are terminated was described this way by Senator Cohen as he responded to Mrs. Kage:

> Senator COHEN. We've moved to the age of the computer. All we have to do is just factor in the age, the amount of the benefits, and when they began, push a button, and out comes a sheet. And that's not good enough . . . The

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[129] Hearing record, p. 64.
[130] Supra fn. 9, p. 10.
[131] Supra fn. 20, p. 25.
[132] Hearing record, p. 19.
[133] Supra fn. 15.

effort to insulate the hearing examiner from the passions of the people, from—I guess the way it was phrased—the emotion, is the very process by which we continue to calcify our indifference. We just remove people from the process and deal with it on a file-by-file, number-by-number basis. And that's what happens. People like you and your husband fall through the cracks in the computer. . . .

But in these cases, when you take something away that somebody has, there ought to be some kind of a face-to-face determination to make that assessment. Otherwise, most people will be treated the same way because the system, the way in which it was designed, its' a large loaded bureaucracy. . . .[134]

C. Inconsistent and Restrictive Standards for Evaluating Cases

Increasing attention has been focused on the growing divergence between declining allowance rates at the state level and the increasing allowance rates of the ALJ level. As stated earlier, several reasons for this growing discrepancy have been identified.[135] Most heavily implicated, however, is the fact that different standards for evaluating disability are applied at the state and the ALJ levels.[136]

The ALJs are governed by the law, federal regulations, Social Security Rulings, and federal court decisions. The state agencies follow the POMS, which amplify the basic standards in the law and regulations, but with distinct differences in key areas. The differences are of several kinds, according to the SSA's own report. In certain cases, definitions in the standards are different, and in others, the definitions may be similar, but different methods of evaluating evidence will lead to different results.[137] Several of the most commonly mentioned examples are discussed below.

1. Meeting the listings

As has been described earlier, the first step in deciding a disability case is to determine the severity of the medical impairment. If the impairment is considered "not severe," the claim is denied.

The SSA has established a list of medical impairments which are severe enough to establish disability without regard to vocational factors. If a person's impairment meets this listing, or a combination of impairments equals a listing in severity, then the claim is granted.

Increasingly, state agencies have been allowing fewer and fewer claims on the basis that the impairment equals the listings. Statistics show that in 1975, 44 percent of all awards of disability benefits were based on equaling the medical listings—cases where the impairment was not specifically described in the listings, but was considered equal in severity, or the combination of several impairments was medically equal to any listed. But by 1981, only about 9 per cent were based on equaling the listings.[138]

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[134] Hearing record, p. 63.
[135] Supra fn. 13.
[136] Supra fn. 20.
[137] Supra fn. 9, pp. 14-15.
[138] Id. at p. 15.

In the GAO's investigation into the CDI process, disability examiners reported that beneficiaries with multiple impairments are being terminated under the CDI reviews because their impairments are being evaluated separately, rather than in combination. The GAO gave this example:

> A 50 year old beneficiary in Ohio suffered from hypertension, diabetes, and depression. Although none of these impairments met the specific listings, the claimant was awarded benefits in 1971 when their combined effect was considered. As part of the ACDI/Periodic Review, the State agency obtained evidence that contained essentially the same findings as that from 1971. However, the State agency now considered the impairments individually and terminated benefits because none met the specific listings.[139]

The POMS also includes a list, unlike the regulations, of 20 examples of non-severe impairments. If the claimant has one of these 20 listed impairments, he or she is found presumptively "non-severe" and denied benefits without consideration of age, education, or work experience as required in the sequential evaluation process defined in the regulations.[140]

Kathleen Grover, a Maine attorney experienced in representing disability beneficiaries, described the problem this way:

> Although the law speaks of disability in terms of total inability to do substantial gainful activity, the initial two levels of review done by the state agency . . . are done only on the basis of whether or not an individual's physical or mental condition meets the criteria of a particular impairment as listed within the regulations. There is no consideration given to medical opinions or other evidence which indicates a continuing disability if that evidence does not directly bring an individual within a specific listed impairment. This is true despite the fact that the Social Security regulations demand consideration of a broad range of vocational and medical aspects of a claim. It is only when an individual's case reaches the administrative law judge that it is fully and adequately reviewed in accordance with the Social Security regulations. Thus, two sets of rules are being used, resulting in an awesome amount of wasted time and effort.[141]

The beneficiaries who suffer the most under these two sets of rules are those with multiple impairments. Because the list of impairments does not deal with multiple impairments, these beneficiaries cannot be fairly adjudicated under the listed impairments and yet, as Ms. Grover continued:

> That is the only criteria applied to determine their degree of impairment. These are the people who will never fit within the listed impairments under the strict construction given by the state agency and so will always be termi-

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[139] Supra fn. 9, p. 15.
[140] POMS DI 2102(c).
[141] Hearing record, p. 85.

> nated from benefits when their claims are reviewed. In most instances, benefits will be reinstated, but only after pursuing the full administrative procedure. This process means an average of 10 to 18 months without benefits.[142]

2. Different evaluation of vocational factors

In determining eligibility, the DI program requires an evaluation of vocational factors when a beneficiary has an impairment and when the person's impairment does not meet or equal one of the medical listings. The purpose of this evaluation is to determine if a combination of medical and vocational factors prevents the claimant from engaging in substantial gainful activity although the medical factors alone do not. Thus the state agency must review the claimant's residual functional capacity along with the physical and mental demands of his previous work in making this determination.[143]

If it is found that the person cannot perform his or her past work, then vocational factors are taken into account to see if the person can do any other work. Under the regulations, if the person cannot return to his former work, his impairment is presumptively "severe" and the burden shifts to the SSA to prove that he can do different work.[144]

Federal regulations also allow a determination of an inability to engage in substantial gainful activity in three other specific instances: where the individual cannot perform even sedentary work; where there is severe pain plus a significant impairment; and, where there is a nonsevere mental disorder which combined with a significant physical impairment precludes work.[145]

Yet these three bases for finding disability are used rarely by the state agencies, and are not included in the POMS although they are in the regulations and do govern ALJs.

After a review of these differences in the evaluation of vocational factors in the disability process, the SSA's own 1981 Bellmon report summarized its findings:

> In summary, an evaluation of the standards and procedures governing the ALJs and the DDSs suggests that variations in definitions and procedures may well be an important cause of the difference in findings, based on the same evidence. . . .[146]

The impact of the different interpretations of vocational factors has produced this result, according to the GAO:

> When reevaluating beneficiaries previously allowed for vocational factors, State agencies now terminate benefits in many of these cases. . . . For example, beneficiaries 49 years or younger with severe impairments that do not meet or equal the listings cannot be found to be disabled unless they are illiterate or unable to communicate in

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[142] Id. at 88–89.
[143] Supra fn. 20, pp. 19–20.
[144] Id.
[145] Id.
[146] Id.

English. Most of the beneficiaries being terminated under this review effort are age 49 or younger.[147]

3. Confusion regarding the role of pain in the disability determination

Federal regulations require that pain be considered as part of the disability decision. If there is objective medical evidence of the source of the pain, then an evaluation of pain must be included in the determination.[148]

The POMS did contain a section on pain which mirrored this regulation, but that section was eliminated from the POMS. In fact, when it was deleted, the written explanation was that "deletion of this section reflects the appreciation that an improper emphasis on the role of pain is conveyed." [149] This resulted in confusion on the role of pain in the state disability determination process despite the federal regulations and federal court decisions requiring pain to be considered.

VIII. FINDINGS

The Subcommittee's principle finding is that many severely disabled persons are being erroneously terminated from the disability insurance program, only to wait without benefits through a lengthy appeals process after which 67 percent are eventually reinstated in the program.

If present trends continue, by the end of 1983, more than 200,000 people will have had their benefits discontinued only to have them reinstated many months later after a hearing before an Administrative Law Judge. In the meantime, they will suffer both financial hardship and emotional trauma. Already some disabled people have committed suicide and others have lost their homes after losing their benefits.

The Subcommittee finds that this needless and unjustifiable result is attributable to several factors—some of which are long-standing problems and others which were created by the way the current reviews were being conducted. The Subcommittee found the following:

(1) Many states have been ill-prepared to handle the flood of CDI cases because of insufficient staff to process the reviews. States received less than a month's notice that thousands of CDI cases would be forwarded to their offices. State hiring freezes have prevented some states from hiring needed additional staff. The tremendous increase in reviews has created a severe strain on state agencies' ability to quickly and thoroughly review cases.

(2) The Social Security Administration does not fully inform disability recipients when notifying them that their cases are under review. The letter sent by the SSA does not stress the gravity of the review but merely says that the agency is checking to determine whether the claimant "continues to meet the eligibility requirements."

Insufficient time is allowed for the recipient to fully respond to the state disability determination.

(3) The initial decision entitling the claimant to benefits is not presumed to be valid. Beneficiaries are having to prove all over again that they are disabled. This burden of proof is not, however, explained to beneficiaries and their doctors, who understandably believe that they have to show only a lack of medical improvement. Inadequate notice to beneficiaries hinders the development of a full and complete medical record. Beneficiaries are not notified that their existing medical history on file with the Social Security Administration is not considered in the decision.

(4) State agencies are poorly developing the medical evidence essential to the disability determination. In reviewing claimants' files, states are disregarding any medical evidence that is

more than two or three months old, thus providing a very distorted and incomplete picture of the claimant's condition. Because the SSA does not require a showing of medical improvement before benefits are terminated, many severely disabled people have been dropped from the program, although their medical conditions have actually deteriorated or remain unchanged.

(5) The SSA is placing an undue reliance on consultative examinations in the review process. The high rate of consultative examinations is attributable to the rush to issue decisions based only on new medical evidence and to the practice of soliciting information from treating physicians in a format which is not useful to the disability determination.

(6) Different, and in some cases, conflicting standards are used for disability determinations, depending on whether the decision is being made by a state claims examiner or an ALJ. The POMS which govern state agency decisions and are issued without public review and comment do not accurately reflect the intent of the federal regulations, and account in part for the differences in allowance rates at the state and ALJ levels.

(7) The appeals process is clogged and lengthy. On average, a claimant has to wait from nine months to a year to obtain a hearing before an ALJ. There is no face-to-face contact between a decision maker and the claimant prior to the ALJ hearing, so that state decisions are based solely on a review of the claimant's file.

The combined effect of these and other factors is that this process is not a "review" of disability at all, but rather a re-determination of disability based on inconsistent and more strict criteria, without notice to beneficiaries or their treating physicians of the true nature of the CDI process.

IX. RECOMMENDATIONS

The Subcommittee recommends that legislation be passed which remedies the structural problems in the CDI process. However, the gravity of the existing problems also requires interim measures to protect beneficiaries while structural reforms are being implemented.

The Subcommittee recommends that the Congress pass interim, short-term legislation which does the following:

(1) Directs the Secretary of Health and Human Services to slow down the rate of the reviews. A reduction in the number of reviews conducted would ease the pressure on the state agencies and would permit more thorough consideration of the pending cases. Since the Social Security Administration is currently operating under the mandate of the 1980 amendments, legislative action would be proper to slow down the fulfillment of that mandate.

(2) Authorizes the continuation of payments to claimants who are awaiting a hearing before an Administrative Law Judge.

It is unfair to terminate benefits prior to a hearing, or any face-to-face contact, particularly given the high reversal rate, since 67 percent of those who appeal are being reinstated. Paying benefits until the ALJ hearing would protect those disabled people whose benefits are terminated erroneously and who would receive these benefits eventually after reinstatement.

To hold down the cost and to discourage frivolous appeals, the legislation would also require individuals whose terminations are affirmed by an ALJ to repay the benefits paid pending appeal.

The Subcommittee recommends that the Congress pass comprehensive legislation which would include the following structural reforms:

(1) Requires that all standards and criteria for disability determinations be promulgated through notice and comment, be made part of Federal regulation, and be considered binding at all levels. Any internal SSA operations instructions would be restricted to procedures for operations only and would not elaborate on substantive issues contained in the regulations.

(2) Requires, in disability reviews, that the Government specifically find that the person has medically improved to such an extent that the person is no longer disabled, or that the initial finding of eligibility was clearly erroneous based on the standards which were in effect at the time the initial decision was made, or that the person is fraudulently in the program.

(3) Revises and streamlines the procedure for disability decisions:

a. The state agency must inform the beneficiary in a detailed and clear notice why and how his or her case will be reviewed, that the review may result in termination of benefits, what the beneficiaries' responsibilities are, and that it may be advisable to seek legal assistance.

b. When the state agency makes its initial finding that the benefits should be terminated, notice must be sent allowing 30 days in which to present additional information, and informing the beneficiary of his or her right to request a face-to-face interview with the disability examiner before the decision is forwarded to the SSA's national office for an official determination.

c. If benefits are then terminated, the beneficiary would have 60 days in which to request an ALJ hearing; the existing reconsideration stage would be eliminated. Only evidence considered at the state level would be admissable at the ALJ level, except for medical evidence of deterioration of condition; all other evidence would be remanded to the state level for consideration there, prior to the ALJ hearing.

d. Benefits would be continued through the appeal to the ALJ.

(4) Includes a clear definition of pain and its role in disability decisions.

(5) Requires the promulgation of regulations governing the use and purchase of consultative examinations, the weight to be given evidence both from consultative and treating physicians, and ways of monitoring the quality and quantity of consultative examinations.

X. CONCLUSION

In mandating that the Social Security Administration conduct periodic reviews of the continuing eligibility of disability insurance beneficiaries, the Congress sought to ensure that only those who are severely disabled and unable to work continue to receive benefits. Nonetheless, as much as Congress wants to remove persons from the program who do not belong there, it also wants to ensure that severely disabled persons remain in the program. The way the current reviews have been conducted has led to the termination of needed benefits for thousands of severely disabled persons and their dependents. Procedures to guarantee a fair and efficient review of eligibility must be implemented if this tragic result is to be stopped.

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